New Patient Information: Adult Form

|  |  |  |
| --- | --- | --- |
| Last:  | First:  | Middle: |
| DOB:  | Sex: ☐M ︎☐F | SS#:  |
| CELL: | Home:  | **Email:** |
| Address St.: | City: | Zip: |
|  | Emergency **Contact** |  |
| Last:  | First:  | Relationship: Ph. #:  |
|  | **Insurance Information** |  |
| Primary Insurer: | ID: | Group #: |
| Secondary Insurer:  | ID#:  | Group #: |  |
| Policy Holder: | Relationship:  | DOB:  |
| SS #: | Employer: | Ph #: |
|  | **BENEFIT INFORMATION** |  |
|  **Please verify your benefits prior to your first appointment.** | **Deductibles and co-pays are due at the time services are rendered.** | **F Code:**  |
|  |
| **Policy Effective Date:** |  |  |
| **Copay: $** | **Deductible: $** | **Deductible Remaining: $****Individual:** **Family:** |
|  |
| **Authorization: Y N** | **Auth. Code:** | **Units: 96130**  **96131** |
|  |
|  |
| **REASON FOR APPOINTMENT:**  |

**Financial Policies**

Payment of services is considered a part of your treatment and is expected at *each session*. We accept most insurances and provide Zelle© instructions on the Patient Forms page of our website: [www.KenfieldWalters.com](http://www.KenfieldWalters.com), The option to use Pay Pal is available to you 24/7 with a 4% charge for transaction fees. Make checks payable to “Kenfield Walters Intl LLC” and request a mailing address from our office.

KWI accepts most insurances but each patient is responsible for payment of services in full at the time that services are rendered until the *annual deductible,* if applicable, is fully paid, and for co-payments at each session as stipulated in the insurer benefit package.

Please initial in the designated places to signify that you have read and agree to each of the policies below:

X\_\_\_\_\_\_\_ I agree to a charge of $110.00 for missed appointments and for cancellations given within less than a 48-hour notification. (This does not apply to Evaluation Services. See Evaluation Signature Documents for that applicable cancellation window. Please ensure that you read and complete these signature documents prior to the evalution.

X\_\_\_\_\_\_\_ I agree to pay immediately a $35.00 “returned check fee” in addition to replacing the amount of a check returned by my bank.

X\_\_\_\_\_\_\_ I agree to report to KWI any changes in my contact information (address, phone #, etc.), insurance, or responsible party prior to the next session appointment. I understand that I alone am responsible for knowing my benefit coverages.

X\_\_\_\_\_\_\_\_ KWI does not carry balances for any services. I agree that if my account remains unpaid for any services more than 30 days, KWI may take legal action to collect the balance at my expense. I agree, as my sole responsibility, to pay *all* attorney fees and court costs for both parties in any dispute *at the time of the hearing.*

X\_\_\_\_\_ I understand that I am financially responsible for services provided, whether reimbursed by my insurer or not. *Any* service fees not covered by my insurer are my sole responsibility.

|  |
| --- |
| **A FEE MAY BE CHARGED FOR ADDITIONAL SERVICES** |
| X \_\_\_\_\_Patient Initials \_\_\_\_\_\_Date:  |  |

**Initialed Acknowledgement of Receipt of HIPAA Privacy Practices**

**X**\_\_\_\_\_\_\_\_\_ I hereby **initial** here to acknowledge that I have been apprised of the availability of a copy of Kenfield Walters Intl LLC “Privacy Policy” that can be downloaded in its entirety at <http://www.kenfieldwalters.com> on the “Patient Forms” page.”

**Consent for Treatment**

**X**\_\_\_\_\_\_\_\_\_ herebyconsent to receive treatment for therapeutic**/**psychological services through Kenfield Walters Intl LLC. I have been notified that the “Consent for Treatment” form can be downloaded at <http://www.kenfieldwalters.com> on the “Patient Forms” page.”

**Initialed Coordination of Care with Primary Care Physician**

I**, X** (Patient Initials) \_\_\_\_\_\_\_\_\_\_☐ Authorize / ☐ Do Not Authorize, the release of any information to my physician by Kenfield Walters Intl LLC and the release of any information to Kenfield Walters Intl LLC by:

|  |  |  |
| --- | --- | --- |
| Physician Name: | Ph. #:  | Fax #: |
| Address: |  City: | MI | Zip: |
| **X Patient/Guardian Signature:**  | **X Date:** |
| **Please check Current symptoms:**

|  |  |
| --- | --- |
| **☐** Anger☐ Anxiety ☐ Appetite Change☐ Crying Spells☐ Decreased Concentration☐ Excessive Worry☐ Feeling Hopeless☐ Weight Change☐ Depression☐ Delusions☐ Self-esteem issues | **☐** Hyperactivity☐ Irritability☐ Mood Swings☐ Paranoia☐ Racing Thoughts☐ Sleep Problems☐ Suicidal Feelings☐ Homicidal Thoughts☐ Overwhelmed**☐** Hallucinations☐ Grief/loss**Other:** |

 | **Current concerns:**

|  |
| --- |
| ☐ Abuse History: \_\_\_\_\_\_\_\_\_\_☐ Academic Issues☐ Behavior Issues☐ Financial Problems☐ Health Issues☐ Legal Issues☐ Grief/Loss☐ Relationship Issues☐ Sexual Issues☐ Substance Abuse: \_\_\_\_\_\_\_☐ Work IssuesOther: |

 |
| **Depression Scale: Patient Mental Health Questionnaire – Circle one answer/number for each question.**Over the past two weeks, how often have you been troubled by any of the following problems? |
|  | **Not at all** | **Sev-eral days** | **More than half of the time** | **Nearly every day** |
| 1. Little interest in doing things. | **0** | **1** | **2** | **3** |
| 2. Feeling down, depressed, or hopeless. | **0** | **1** | **2** | **3** |
| 3. Trouble falling or staying asleep. | **0** | **1** | **2** | **3** |
| 4. Feeling tired or having little energy. | **0** | **1** | **2** | **3** |
| 5. Poor appetite or overeating. | **0** | **1** | **2** | **3** |
| 6. Feeling bad about yourself or that you are a  failure or have let yourself or your family down. | **0** | **1** | **2** | **3** |
| 7. Trouble concentrating on things, such as reading. | **0** | **1** | **2** | **3** |
| 8. Moving or speaking so slowly that other people  could have noticed, or being so fidgety that you  have been moving around a lot more than usual. | **0** | **1** | **2** | **3** |
| 9. Thoughts that you would be better off dead, or  hurting yourself.  | **0** | **1** | **2** | **3** |
|  Column Totals |  |  |  |  |
| **SOCIAL INFORMATION** |
| 1. Do you usually spend leisure time: ☐ Alone ☐ With family ☐ With friends2. Describe your strengths: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_3. List your hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SUICIDAL ISSUES** |
| 1. Have you ever thought about suicide? ☐ No ☐ Yes2. Do you have a history of suicide attempts? ☐ No ☐ Yes Date of most recent if yes: \_\_\_\_\_  How?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. Do you currently feel suicidal now? ☐ No ☐ Yes Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **EDUCATION**  |
| ☐ Did not complete High School ☐ High School Diploma ☐ GED ☐ Vocational Training ☐ Associate’s Degree ☐ Bachelor’s Degree ☐ Master’s Degree ☐ Doctorate / Psy D. ☐ MD/DOSchool: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Final GPA: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you experienced academic difficulties? ☐ No ☐ Yes If, yes, When ?:\_\_\_\_\_\_\_\_\_\_\_ Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. Have you experienced behavior problems in school? ☐ No ☐ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **OCCUPATION** |
| ☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Employed Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Sources of support: ☐ Self-support ☐ Full/Part Time Job ☐ Parents ☐ Spouse ☐ Retirement ☐ Disability |
| Have you ever been in the military? ☐ No ☐ Yes: ☐ Army ☐ Air Force ☐ Coast Guard ◻ Navy ︎ Marines Enlistment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Circle): Honorable / Dishonorable Discharge Date: \_\_\_\_\_\_ |
| Are you having issues at work? Circle: No Yes: If yes, please explain:**FAMILY INFORMATION** |
| Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widow(er) |
| Children: ☐ I do not have children |
| **Name** | **Age** |  **Dates of Marriage &/or Divorce** | **Lives with you?** |
| Spouse(s): |  |  |  ☐ No ☐ Yes |
|  |  |  |  ☐ No ☐ Yes  |
|  |  |  |  ☐ No ☐ Yes  |
| Children: |  |  **Biological/Step/Adopted** |  ☐ No ☐ Yes |
|  |  |  |  ☐ No ☐ Yes |
|  |  |  |  ☐ No ☐ Yes  |
|  |  |  |  ☐ No ☐ Yes  |
| Siblings: |  |  |  ☐ No ☐ Yes |
|  |  |  |  ☐ No ☐ Yes |
|  |  |  |  ☐ No ☐ Yes  |
|  |  |  |  ☐ No ☐ Yes |
|  |  |  |  ☐ No ☐ Yes  |
|  |  |  |  ☐ No ☐ Yes  |
| **Describe your relationships with family members:**At Childhood: ☐ Poor ☐ Strained ☐ Good ☐ ExcellentAt Adulthood: ☐ Poor ☐ Strained ☐ Good ☐ ExcellentAt Present: ☐ Poor ☐ Strained ☐ Good ☐ Excellent |  |  |  ☐ No ☐ Yes |
| Were you raised in a home that practiced a religion? ☐ No ☐ YesDo you currently practice a religion? ☐ No ☐ Yes☐ Catholic ☐ Christian ☐ Hindu ☐ Jewish ☐ Protestant ☐ Muslim ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  ☐ No ☐ Yes |
| **Ethnic Group:** ☐ African-American/Black ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **LEGAL HISTORY** |
| (Circle) Are you currently and/ or have been in the past involved in a: ☐ Custody Suit, Date: \_\_\_\_\_\_\_\_\_ ☐ On Probation, Date(s): \_\_\_\_\_\_\_\_\_ ☐ DUI/OWI Conviction(s), Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Divorce(s), Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Other Legalities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **MEDICAL HISTORY** |
| **Describe Your current health:**☐ Poor ☐ Fair ☐ Good ☐ Very good | **Are you experiencing physical pains at this time?**☐ No ☐ Yes: Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Medical Problem Experienced: | **About Myself - Use Dates**  | **About Family Members / Dates** |
|  | **Current/****Recent** |  **Past** | ☐ Mother ☐Father ☐Sibling |
| Abuse: Emotional/Physical/Sexual |  |  | ☐ Mother ☐Father ☐Sibling |
| Alcohol Abuse…&/or Inpatient hospitalization… |  |  | ☐ Mother ☐Father ☐Sibling☐ Mother ☐Father ☐Sibling |
| ADD/ADHD |  |  | ☐ Mother ☐Father ☐Sibling |
| Anxiety |  |  | ☐ Mother ☐Father ☐Sibling |
| Asthma |  |  | ☐ Mother ☐Father ☐Sibling |
| Appendicitis |  |  | ☐ Mother ☐Father ☐Sibling |
| Bed wetting |  |  | ☐ Mother ☐Father ☐Sibling |
| Birth defects |  |  | ☐ Mother ☐Father ☐Sibling |
| Bulimia |  |  | ☐ Mother ☐Father ☐Sibling |
| Cancer |  |  | ☐ Mother ☐Father ☐Sibling |
| Chest pain |  |  | ☐ Mother ☐Father ☐Sibling |
| Constipation |  |  | ☐ Mother ☐Father ☐Sibling |
| Chicken Pox |  |  | ☐ Mother ☐Father ☐Sibling |
| Diabetes |  |  | ☐ Mother ☐Father ☐Sibling |
| Diarrhea |  |  | ☐ Mother ☐Father ☐Sibling |
| Fainting |  |  | ☐ Mother ☐Father ☐Sibling |
| Hearing |  |  | ☐ Mother ☐Father ☐Sibling |
| High blood pressure |  |  | ☐ Mother ☐Father ☐Sibling |
| Migraines |  |  | ☐ Mother ☐Father ☐Sibling |
| Nausea |  |  | ☐ Mother ☐Father ☐Sibling |
| Psychiatric hospitalization  |  |  | ☐ Mother ☐Father ☐Sibling |
| Stroke |  |  | ☐ Mother ☐Father ☐Sibling |
| Other hospitalization(s) |  |  | ☐ Mother ☐Father ☐Sibling |
| Other Issues: |  |  | ☐ Mother ☐Father ☐Sibling |
| **MEDICATION LOG** |
| List Prescribed or over-the-counter medication(s) or herbal supplements you currently take: Add additional sheets of paper if needed.  |
| **Medication** | **Daily Dosage**  | **Reason for Use** | **Use Dates: mm/yyyy** |
|  |  |  | From: To: |
|  |  |  | From: To:  |
|  |  |  | From: To: |
|  |  |  |  |
| Allergies/Side Effects:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **MEDICAL HISTORY CONTINUED** |
| List any major accidents or surgeries: ☐ Not applicableSurgeries(s): Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Accidents(s): Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Do you have any diet or nutritional concerns: ☐ No ☐ Yes: Your Height:\_\_\_\_\_\_\_\_Have you gained weight in the last 60 days: ☐ No ☐ Yes: How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you lost weight in the last 60 days: ☐ No ☐ Yes: Lbs: \_\_\_\_\_\_\_\_\_\_\_\_Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you ever: ☐ overeat ☐ induce vomiting ☐ Use laxatives ☐ Exercise to get rid of calories ☐ Skip meals |
| **SUBSTANCE USE** |
| **ALCOHOL USE:** Do you currently drink? ☐No ☐ Yes What is your consumption weekly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever been told to cut down on your drinking? ☐ No ☐ YesHave you ever felt bad about your drinking habits? ☐ No ☐ YesHave you ever attended an AA group? ☐No ☐ Yes: When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever been convicted of an: ☐MPI ☐DWI ☐ OWI? When? \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_Have you been treated as an *outpatient* for alcohol use: ☐ No ☐Yes - Dates:\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_ Have you been treated as an *inpatient* for alcohol use? ☐ No ☐Yes - Dates: \_\_\_\_\_\_\_\_\_\_\_\_ Facility?\_\_\_\_\_\_\_\_\_\_\_ |
| **DRUG USE**Do you / have you use/(d) illegal drugs, or non-prescription medication now or in the past? ☐ No ☐ YesCircle Drugs Used: ☐ Amphetamines ☐ Crack/Cocaine Heroine Opiates ︎ Fentanyl Marijuana Vaping/ Substance of Choice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you use/amount?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever attended an NA meeting? ☐ No ☐ Yes Date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever been treated as an *outpatient* for drug use? ☐No ☐Yes Date(s): \_\_\_\_\_\_\_\_\_\_\_\_Have you ever been treated as an *inpatient* for drug use? ☐ No ◻Yes Date(s): |
| CAFFEINE USE: ☐ Not applicableCoffee: Cups per day ☐ 1 ☐2 ☐3 ☐4+Tea: Cups per day: ☐1 ☐2 ☐3 ☐4+Energy Drinks: ☐1 ☐2 ☐3 ☐4+ |
| SMOKING: Check the response that best summarizes your cigarette smoking status:☐ Never smoked ☐ Former smoker / Vape: Month/Year Quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Current Smoker: Average number of cigarettes/vape smoked per day: \_\_\_\_\_\_\_\_ |
| **THERAPY GOALS****Please list what you hope to accomplish during therapy** |
| 1. |
| 2.   |
| 3. |

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Patient/Guardian Signature**